CHAPTER 13
SECTION 4

APPEALS OF MEDICAL NECESSITY DETERMINATIONS

Medical necessity determinations are determinations based on medical necessity, appropriate level of care, custodial care (as these terms are defined in 32 CFR 199.2) or other reason relative solely to reasonableness, necessity or appropriateness. Determinations relating to mental health benefits under 32 CFR 199.4 are considered medical necessity determinations.

1.0. INITIAL DETERMINATION

A determination issued (following review by a second level reviewer) that the health care services furnished or proposed to be furnished to a patient are not medically necessary is an initial denial determination and is appealable under Chapter 13, Section 4.

1.1. Opportunity For Discussion Of Proposed Denial Determination In Preadmission/ Preprocedure And Concurrent Review Cases

In preadmission / preprocedure and concurrent review cases, the contractor shall provide an opportunity to discuss a proposed initial denial determination. Before issuing an initial denial determination, the contractor shall:

- Promptly notify the provider or supplier and the patient's attending physician (or other attending health care practitioner) of the proposed determination; and

- Afford an opportunity for the provider or supplier and the physician (or other attending health care practitioner) to discuss the matter with the contractor physician advisor and to explain the nature of the patient's need for health care services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of inpatient care.

1.2. Notice of Initial Denial Determination

The notice of the initial determination shall, where applicable, address waiver of liability for services found to be not medically necessary and include notice of appropriate appeal rights. (Refer to Chapter 13, Section 1, paragraph 2.2.1. for the content of the notice of initial determination.) If the provider was verbally notified of the initial determination prior to issuance of the written initial determination, the time and date of the verbal notification shall be included in the Notice of the Initial Determination. The contractor shall provide written Notice of an Initial Determination to:

- The patient unless the patient is represented by a guardian or other representative. If the patient is represented by a guardian or other representative, then the notice will be addressed and provided to the guardian or representative.

- The attending participating physician, or other participating health care provider, and

- The facility, if one is involved.

1.3. Timing Of The Notice

The contractor shall ensure notices are delivered within the following time periods. (Reference paragraph 1.2. regarding beneficiaries represented by guardians or other representatives. If the beneficiary is represented in the appeal, the notice must be delivered to the beneficiary's representative, or, in the case of a minor beneficiary, to the parent or guardian of the minor beneficiary unless the claim was filed by the minor beneficiary.)

1.3.1. For admission, on the first working day after the determination that the services are not medically necessary.

1.3.2. For continued stay, (e.g., outliers in facilities under a prospective payment system), by the first working day after the determination that the services are not medically necessary if the beneficiary is still in the facility, and within three working days if the beneficiary has been discharged.

1.3.3. For preprocedure review, before the procedure is performed.

1.3.4. For preadmission review, before admission.

1.3.5. For retrospective review (excluding DRG validation), within three working days after the determination that the services are not medically necessary.

1.3.6. For post-procedure review, within three working days after the determination that the services are not medically necessary.

NOTE: If the beneficiary is an inpatient, and is not a minor or represented, notices must be delivered to the beneficiary in the facility.

1.4. Preadmission/Preprocedure Review

In the case of preadmission review, the contractor shall document the date that the patient (or representative) and the facility received notice of the initial denial determination. If notice to the provider was verbal, the date and time of the verbal notice, and to whom the verbal notice was given, must be documented.

1.5. Effect Of The Initial Denial Determination

The initial determination is final and binding unless the initial determination is reopened by the contractor or revised upon appeal.

2.0. CONTRACTOR RECONSIDERATIONS

The contractor shall develop a written plan for and implement a formal appeals system that incorporates the requirements for reconsiderations of initial denial

determinations. The opportunity for reconsideration shall be stated in the contractor's initial denial determination regarding the medical necessity, reasonableness or appropriateness of admission, continued stay, outlier days, and/or services rendered.

2.1. Right To Contractor Reconsideration

The contractor shall establish procedures to ensure a beneficiary (or representative) and provider are notified in the initial denial notice of their right to a reconsideration of a contractor's initial denial determination (refer to Chapter 13, Section 1, paragraph 2.2.1.). These parties may request a reconsideration if there is an amount in dispute, regardless of the dollar amount controversy. The following issues are subject to reconsideration if either the beneficiary and/or provider is dissatisfied with an initial denial determination:

- Reasonableness, medical necessity and appropriateness of the services furnished or proposed to be furnished.
- Appropriateness of the setting in which the services were or are proposed to be furnished.
- Whether the party is financially liable. The beneficiary who has been found liable may obtain a reconsideration of that determination. A provider may obtain a reconsideration of the determination whether the beneficiary is or is not liable. If a beneficiary or provider requests a reconsideration of the issues in the above paragraphs, the contractor shall make a determination of the limitation of liability issue at the same time.

2.2. Request For Contractor Reconsideration

The contractor shall allow a beneficiary (or representative) and/or non-network participating provider to submit a written request for reconsideration to the contractor. The contractor shall establish unique post office boxes or addresses for submission of reconsideration requests. The following limitations apply:

- Only a beneficiary (or appointed representative) may submit a written request for an expedited reconsideration of preadmission/preprocedure.
- When continued certification is denied during concurrent review, and the beneficiary is still in the facility, only the beneficiary (or appointed representative) may request a reconsideration.
- A beneficiary or a non-network participating provider may request a nonexpedited reconsideration.

2.3. Timeframes For Reconsideration Requests

The contractor shall reconsider an initial denial determination if a written request is made by an appropriate appealing party within the following time frames:

2.3.1. Concurrent Review Denial

In order to file a request for reconsideration of a concurrent review denial determination, the beneficiary must be a patient in the facility on the date of appeal filing. The beneficiary is encouraged to file no later than noon of the day following the day of receipt of the initial denial determination. The date of receipt of the initial determination by the beneficiary shall be considered to be five calendar days after the date of the initial determination, unless the receipt date is documented. A request for reconsideration received after the reconsideration filing deadline, but which is postmarked or received within 90 calendar days from the date of the initial determination, shall be accepted. These requests shall be automatically forwarded on the date of filing to the NQMC for a reconsideration determination. (Refer to paragraph 2.6.2.)

2.3.2. Preadmission/Preprocedure Denial

A request for an expedited reconsideration of a preadmission / preprocedure denial must be filed by the beneficiary within three calendar days after the date of the receipt of the initial denial determination. The date of receipt of the request for reconsideration shall be considered to be five calendar days after the date of mailing of the initial denial determination, unless the receipt date is documented. Appeals filed after the expedited appeal filing deadline will be treated as nonexpedited appeals. In situations where the preadmission / preprocedure appeal is treated as nonexpedited, it is imperative that the contractor obtain current status as to the patient's medical condition prior to issuing the reconsideration determination, as the beneficiary's condition may be ever changing. If during the processing of an appeal of a preadmission / preprocedure denial, the beneficiary received the denied service or supply, the contractor shall obtain the medical records and treat the appeal as nonexpedited.

2.4. Nonexpedited Denial

All other requests for reconsideration must be filed within 90 calendar days after the date of the initial denial determination. The request shall be considered to be filed as of the date the request is postmarked, or, if the request does not have a postmark, it shall be considered filed on the date it is received by the contractor.

2.5. Contractor Requirement To Provide Information

With the exception of reconsiderations of concurrent review initial denial determinations, which are conducted by the NQMC, when a reconsideration is requested and prior to the issuance of the reconsideration determination, the contractor shall provide all appealing parties an opportunity to examine and obtain documents and information upon which the initial denial determination is made. (Refer to Chapter 13, Section 3, paragraph 4.3.2.2. regarding contractor information that shall be included in the appeal file provided to TMA.)

2.5.1. All parties to the reconsideration shall be informed that they may be charged the costs of photocopying and postage as established by TMA. Reimbursement is currently set at $.07 a page plus first class postage.

2.5.2. All parties shall be informed of their opportunity to present documenting materials or additional information for consideration.

2.6. Contractor Reconsideration Proceedings

2.6.1. Other Than Reconsiderations Of Concurrent Review Initial Denial Determinations

The contractor shall follow the following reconsideration procedures:

- The contractor shall give advance notice of the date that the reconsideration determination will be issued to allow sufficient time for the preparation and submission of additional information.
- The contractor shall reschedule the reconsideration if a party submits a written request presenting a reasonable justification for rescheduling.
- A reconsideration determination shall be based on the information that led to the initial determination, all information found in the medical record, and additional information submitted by the beneficiary or provider. If the beneficiary or provider fails to submit requested additional documentation, the reconsideration determination will be based on the available documentation.
- The beneficiary and/or provider must present the additional information in writing.
- Parties shall be informed that they will receive written notification of the reconsideration determination after the reviewing physician has reviewed the case.

2.6.2. Reconsiderations Of Concurrent Review Initial Denial Determination

When the beneficiary remains an inpatient and files a timely request for a reconsideration, the contractor shall immediately notify the NQMC by telephone or facsimile on the date of filing, and overnight mail to the NQMC the complete medical record and all supporting documentation regarding the initial denial determination and any other documents provided by the beneficiary and/or provider. Facsimiles may be utilized in the event the documentation is not more than ten pages in volume. The NQMC shall review the request for reconsideration and notify the contractor and all parties of its decision regarding the request. (Refer to paragraph 3.1.1.)

2.6.3. Timing Of Contractor Determinations

The contractor shall complete reconsideration determinations and send written notices to the parties involved within the following time frames (42 CFR 473.32):

- Expedited Preadmission/Preprocedure Reconsideration Determinations - Three working days after receipt of a request for an expedited reconsideration, the contractor shall issue the reconsideration determination unless the

contractor reschedules the reconsideration at the request of the appealing beneficiary.

- Nonexpedited Reconsideration Determinations - Thirty calendar days after receipt of a request for a nonexpedited reconsideration, the contractor shall issue the reconsideration determination unless the contractor reschedules the reconsideration at the request of the appealing party.

2.6.4. Notice Of Contractor Determination

The contractor shall issue a written notice of the reconsideration determination. Refer to Chapter 13, Section 3, paragraph 6.0. for the required content of the notice to the appealing party of the results of the reconsideration determination. Timeframes for filing a request for a reconsideration by the NQMC are addressed in Chapter 13, Section 3, paragraph 6.6.1.

3.0. RECONSIDERATIONS BY THE NQMC

The NQMC is responsible for reviewing requests from beneficiaries and/or providers for an appeal of a reconsideration when a contractor upholds an initial denial determination on reconsideration. The NQMC is also responsible for issuing reconsideration determinations in concurrent review cases. The timeframes for reconsideration requests set forth in paragraph 2.3.2. and 2.4., also apply to reconsideration requests filed with the NQMC.

3.1. Timing Of NQMC Reconsideration Determinations

3.1.1. Reconsideration Of Concurrent Review Initial Denial Determinations

The NQMC shall complete a reconsideration determination for a concurrent review initial denial determination within two working days and shall notify all parties and the contractor of the reconsideration determination within three working days after the receipt of the reconsideration request from the contractor by the NQMC. The contractor shall automatically provide to the NQMC by facsimile or overnight mail, all required documentation on the day of the receipt of the reconsideration request. If the beneficiary is discharged while the concurrent review is being performed by the NQMC, the NQMC will return the case file to the contractor by overnight mail with a letter advising the contractor that because the beneficiary has been discharged, a nonexpedited, retrospective reconsideration by the contractor is appropriate. The NQMC will notify the appealing party, in writing, of the action taken. The contractor will accept the case as a nonexpedited reconsideration with the reconsideration receipt date being the date of receipt of the case file from the NQMC.

3.1.2. Reconsideration Of A Preadmission/Preprocedure Reconsideration Denial Determinations

Within three working days of receipt of a request from a beneficiary for an expedited reconsideration, the NQMC shall complete its review and notify all parties and the contractor of the results of the review. The NQMC shall request from the contractor all documentation, including the medical record, regarding the initial denial and

reconsideration determination. The contractor shall provide all requested documentation by overnight mail or facsimile. If, during the processing of an appeal of a preadmission/preprocedure denial, the beneficiary receives the denied services or supplies, the NQMC shall obtain the medical record and treat the appeal as nonexpedited.

3.1.3. Nonexpedited Reconsiderations

The NQMC shall complete reviews for all other requests for appeals of reconsideration denial determinations made by the contractor and notify all parties within 30 calendar days after the date of receipt of the reconsideration request. The NQMC shall request from the contractor all documentation including the medical record, regarding the initial denial and reconsideration determination within one day of receipt of the request for reconsideration. The contractor shall provide all requested documentation within five working days.

3.2. Notice

The NQMC shall issue a written notice of the reconsideration determination using the suggested format and content set forth in Chapter 13, Section 3, paragraph 6.0. as guidance.

3.3. Effect

The NQMC's reconsideration determination is final and binding upon all parties unless it is:

3.3.1. Reopened and revised by the NQMC, either on its own motion or at the request of a party, within one year from the date of the reconsidered determination.

3.3.2. Reopened and revised by the NQMC, after one year but within four years because: the NQMC receives new and material evidence; or there is a clerical error in statement of the NQMC's reconsideration determination; or the NQMC erred in an interpretation or application of TRICARE coverage policy; or there is an error apparent on the face of the evidence upon which the NQMC's reconsideration was based.

3.3.3. Reopened and revised by the NQMC at any time, if the reconsideration determination was obtained through fraud or an abusive practice, e.g., describing services in such a way that a wrong conclusion is reached; or

3.3.4. Reversed upon appeal at hearing in accordance with provisions of 32 CFR 199.10 and 199.15.

3.3.4.1. Beneficiaries may appeal an NQMC reconsideration determination to TMA and obtain a hearing on such appeal to the extent allowed under the procedures in 32 CFR 199.10(d).

3.3.4.2. A non-network participating provider may appeal an NQMC reconsideration determination to TMA and obtain a hearing on such appeal to the extent allowed under the procedures in 32 CFR 199.10(d). The issue in a hearing requested by a provider is limited to waiver of liability (i.e., whether the provider knew or could reasonably have been expected

to know that the services were excludable) (refer to paragraph 4.0.). Because waiver of liability applies only to services retrospectively determined to be potentially excludable, waiver of liability will not apply in concurrent review or preadmission / preprocedure cases (i.e., non-network participating providers may request hearings only in cases involving retrospective determinations with the issue being limited to waiver of liability).

3.3.4.3. Further appeal of a preadmission / preprocedure denial to the hearing level is not permitted unless the requested services have commenced. An appeal to a hearing where the services have not commenced is not allowed because there would not be an adequate remedy should the hearing final decision hold in favor of the beneficiary. This is because the issue at hearing would be whether the medical documentation at the time of the request for preadmission / preprocedure demonstrated medical necessity for the services requested. A final decision issued as a result of the hearing process (which may take several months to complete) holding that the beneficiary met the requirements for preadmission / preprocedure on the date the preadmission / preprocedure request was made could not be implemented as the circumstances that warranted the services at the time of the initial request would unquestionably have changed.

3.4. Record

Refer to Chapter 13, Section 3, paragraph 9.0. for the record of the reconsideration to be maintained by the NQMC.

4.0. WAIVER OF LIABILITY POLICY

The contractor shall establish procedures that ensure the beneficiary and the provider are protected in instances where they did not know or could not reasonably have been expected to know that health care services rendered would not be covered as a result of denial determinations made by the contractor and the NQMC. For information relating to Waiver of Liability, refer to the Policy Manual, Chapter 13, Section 16.1.